

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County *Garnett*

Village or City *Oakland* (No. ....)

688

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *166*

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

137

2 FULL NAME *Orpha M. Bugman*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word)

## 6 DATE OF BIRTH

*January 15, 1881*  
(Month) (Day) (Year)

## 7 AGE

*33 yrs. 11 mos. 18 ds.*

If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. *H. W.*  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE  
(State or country)*West Va.*

## 10 NAME OF FATHER

*Tom Cornell*11 BIRTHPLACE OF FATHER  
(State or country)*Unknown*

## 12 MAIDEN NAME OF MOTHER

*Suzie Sheppard*13 BIRTHPLACE OF MOTHER  
(State or country)*W. Va.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Suzie Cornell*

(Address) *W. Va., Md.*

## 15

Filed *Jan. 4th, 1915* Name *Mary S. White*  
Dep. Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*Jan. 3, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Dec. 17, 1914*, to *Jan. 3, 1915*,

that I last saw him alive on *Jan. 3, 1915*,

and that death occurred on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Puerperal Septicemia*

(Duration) yrs. 2 mos. ds.

Contributory *Broncho Pneumonia*  
(Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) *J. M. Darby*, M. D.  
*Jan. 3, 1915* (Address) *Oakland, Md.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Oakland*

## DATE OF BURIAL

*Jan. 5th, 1915*

## 20 UNDERTAKER

*D. C. Borden*

## ADDRESS

*Oakland, Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *periosteum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *sepsis*, *ictonus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1918

BUREAU, U. S.



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.* *Carcin-* "oma. *Sarcoma*, etc. of ..... (name origin: "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Cox-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1915

BUREAU. V.S.

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1 PLACE OF DEATH  
County Garrett

Village or City near Oakland (No. ....)

690

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 166

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Annie Mariah Cochard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH

July 15, 1860  
(Month) (Day) (Year)

7 AGE

54 yrs. 5 mos. 22 ds. 11 LESS THAN  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Jan. 7th, 1915 Marie S. White  
Dep. Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 6, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec 38, 1914, to Jan 4, 1915,  
that I last saw him alive on Jan 4, 1915,

and that death occurred on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH was as follows:

Tempo Cholera  
.....

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
(Signed) John M. Doran, M. D.  
Jan 7, 1915 (Address) Oakland, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 PLACE OF BURIAL OR REMOVAL

At place  
of death yrs. mos. ds. In the  
State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

DATE OF BURIAL

20 UNDERTAKER

D. S. Bolden ADDRESS  
Oakland Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcin-*oma. *Sarcoma*, etc., of ..... (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chro-  
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dental; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)  
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## 1 PLACE OF DEATH

County Garrett (No. 8)

Village or City Hoyes Run (No. 8)

691

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 165

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Esther Leolya Friend

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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## 6 DATE OF BIRTH

April 30, 1911  
(Month) (Day) (Year)

## 7 AGE

3 yrs. 8 mos. 22 ds.  
If LESS than  
f day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
At Home  
~~Office~~

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Garrett County, Md.

## PARENTS

## 10 NAME OF FATHER

Walter R. Friend

## 11 BIRTHPLACE OF FATHER

(State or country)

Garrett County, Md.

## 12 MAIDEN NAME OF MOTHER

Mary L. Friend

## 13 BIRTHPLACE OF MOTHER

(State or country)

Garrett County, Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter R. Friend

(Address) Simes, Md.

15

Filed 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

January 22, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Jan 21st, 1915, to Jan 22, 1915,

that I last saw her alive on Jan 21, 1915,

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH\* was as follows:

Membranous Laryngitis

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

Angina pectoris

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) C. P. W. Snyder, M. D.

422, 1915 (Address) Accident mil.

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Hoyes Run, Grass yard.

## DATE OF BURIAL

Jan 23, 1915

## 20 UNDERTAKER

Fries, Simes

## ADDRESS

Simes, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

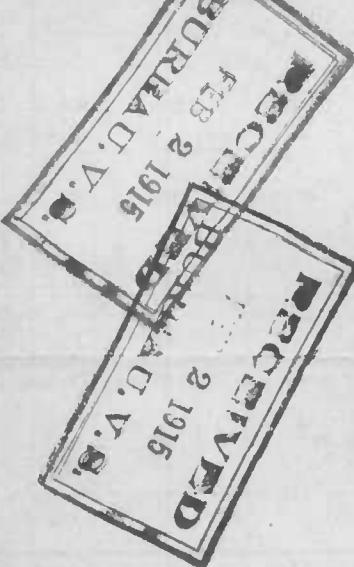
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avold use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Genital," "Seuile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Miasma," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Garrett

Village or City Friendsville (No. 114),

2 FULL NAME Harriet Guard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>MARRIED</u>
---------------------	------------------------------	--

6 DATE OF BIRTH  
January 20, 1866  
(Month) (Day) (Year)

7 AGE 48 yrs. 2 mos. 6 ds. OR min. ?  
It LESS than  
1 day, .... hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) General house work

9 BIRTHPLACE  
(State or country) Garrett Co Md

10 NAME OF FATHER John Savage

11 BIRTHPLACE OF FATHER  
(State or country) Md

12 MAIDEN NAME OF MOTHER Julia A. Umble

13 BIRTHPLACE OF MOTHER  
(State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(informant) Jasper Guard  
(Address) Friendsville Md

15  
Filed Jan 28th, 1915 John H. French  
Local REGISTRAR

692

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 161St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 26th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th 1914 to Jan 26th, 1915,  
that I last saw her alive on Jan 25th, 1915,  
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

Biliary Calculi

Contributory (Secondary) Obliterated gall bladder  
(Duration) 4 yrs. 6 mos. 6 ds.

(Signed) Dr. H. C. Nadrang, M.D.  
(Address) Friendsville Md  
(Duration) 1 yrs. 6 mos. 6 ds.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence at place of death

19 PLACE OF BURIAL OR REMOVAL Friendsville Md DATE OF BURIAL Jan 28 1915

20 UNDERTAKER J. Savage Friendsville Md ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Honestwife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcin-*

Original

oma

*Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drowsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 2 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Garrett

W. Va.

Village or City Gomania (No.)

693

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 167St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ellen Jenkins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widow

6 DATE OF BIRTH

July 3, 1858  
(Month) (Day) (Year)7 AGE 57

yrs.

mos.

If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

ds.

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)House WorkDomestic9 BIRTHPLACE  
(State or country)Pa.10 NAME OF  
FATHERHenry Miller11 BIRTHPLACE  
OF FATHER  
(State or country)Pa.12 MAIDEN NAME  
OF MOTHEREllen Miller13 BIRTHPLACE  
OF MOTHER  
(State or country)Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. G. Dimmick, M.D.

(Address)

Gomania, W. Va.

15

Filled

Jan. 6, 1915 I. W. Bremathy

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan.31915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 2nd, 1915 to Jan. 3rd, 1915  
that I last saw her alive on Jan. 2nd, 1915and that death occurred on the date stated above, at 12409 a.m.

The CAUSE OF DEATH\* was as follows:

ParalysisContributory  
(Secondary)smo(Duration) 1 mo yrs. mos. ds.(Signed) W. G. Dimmick, M.D. (Address) Gomania, W. Va.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 mo yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.Where was disease contracted,  
If not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Wilson Cem.

## DATE OF BURIAL

Jan. 5th, 1915

## 20 UNDERTAKER

John Franklin

## ADDRESS

Gomania, W. Va.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death—**Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

oma

*Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Oxygenal," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mania," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Garrett

Village or City Merrill (No.)

694

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 162St.      Ward     

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs. Will McIntyre

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH

Aug 26, 1880  
(Month) (Day) (Year)

7 AGE

34 yrs. 5 mos. 29 ds. If LESS than  
1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Housewife

9 BIRTHPLACE

(State or country)

W. Va.

## PARENTS

10 NAME OF FATHER

Wm. Harvey

11 BIRTHPLACE OF FATHER

(State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Hester Wilson

13 BIRTHPLACE OF MOTHER

(State or country)

W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. D. W. Crowe

(Address) New Germany

15

Filed     , 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 20th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Oct 6th, 1914, to Jan 17th, 1915,

that I last saw her alive on Jan 17th, 1915,

and that death occurred on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Parenchymatous Hepatitis

(Duration) yrs. 6 mos. 0 ds.

Contributory  
Secondary

(Duration) yrs. 0 mos. 0 ds.

(Signed) P. C. Bowen, M. D.

Jan 21, 1915 (Address) Grantsville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death yrs. mos. ds. State yrs. mos. ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Sayer W. Va. Jan 20, 1915

20 UNDERTAKER

A. Speir & Son     

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

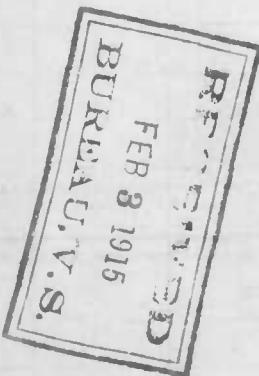
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis" etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County *Garrett*Village or City *Bromleyton Md.*

695

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *163*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Charles F. Mallon*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>MARRIED</i>
-------------------	------------------------------	--

6 DATE OF BIRTH <i>Aug.</i>	<i>14</i>	<i>1899</i>
	(Month)	(Day)

7 AGE <i>56</i>	If LESS than 1 day, .... hrs. OR .... min. ?
<i>11</i>	<i>14</i>
Yrs. <i>11</i>	Mos. <i>14</i>
ds.	

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work *Leather Clark.*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Coal Mining*

9 BIRTHPLACE  
(State or country) *Maryland*10 NAME OF FATHER *Andrew Mallon*11 BIRTHPLACE OF FATHER  
(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Estherine Patterson*13 BIRTHPLACE OF MOTHER  
(State or country) *Maryland*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. H. Mallon*(Address) *Bromleyton Md.*

15

Filed *1915*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan. 14th*  
(Month) *Jan.* (Day) *14* (Year) *1915*

17 I HEREBY CERTIFY, THAT I attended deceased from

*Jan. 14th, 1915* to *Jan. 15th, 1915*

that I last saw him alive on *Jan. 14th, 1915*

and that death occurred on the date stated above, at *11:30 p.m.*

The CAUSE OF DEATH was as follows:

*Pyphritis*  
*Relitation of Heart*  
*Arrrest of heart*

(Duration) *1* yrs. *0* mos. *0* ds.

Contributory  
(Secondary)

(Duration) *1* yrs. *0* mos. *0* ds.

(Signed) *H. W. Mallon* (Address) *Bromleyton Md.* M. D. *1915*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *all his life* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Bromleyton Md.* (Address) *Jan. 15th, 1915*

## 20 UNDERTAKER

*W. H. Mallon* (Address) *Bromleyton Md.*

# REVISED UNITED STATES STANDARD

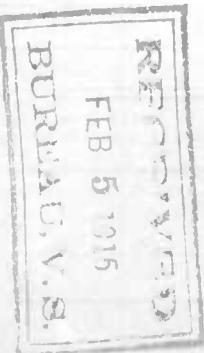
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*oma, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ab-*themia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-*genital*," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-*mus*," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæ-*mia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County GarrettVillage or City Near Bayard W Va (No.)

696

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 167St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lillie Grant Nine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
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6 DATE OF BIRTH <u>Jan. 30</u>	1870
	(Month) (Day) (Year)

7 AGE <u>44</u>	8 If LESS than 1 day, .... hrs. OR .... min. ?
yrs. 11 mos. 4 ds.	

9 OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u>
(b) General nature of industry, business, or establishment in which employed (or employer) <u></u>

10 NAME OF FATHER <u>Thomas Morland</u>
11 BIRTHPLACE OF FATHER (State or country) <u>West. Va</u>

12 MAIDEN NAME OF MOTHER <u>Dorothy J. White</u>
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant) <u>E. B. Johnson M.D.</u>
(Address) <u>Bayard W Va</u>

15 Filed <u>Jan 5<sup>th</sup>, 1915</u>	16 I. W. Abernathy Local REGISTRAR
--	---------------------------------------

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 4, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1914, to Jan 4, 1915,that I last saw her alive on Jan 3, 1915,and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus

18 (Duration) <u>8 days</u>	19 (Duration) <u>8 days</u>
20 Contributory (Secondary) <u></u>	21 (Duration) <u>8 days</u>

22 (Signed) <u>E. B. Johnson</u>	23 (Address) <u>Bayard W Va</u>
	M. D.

24 *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.
--

25 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death <u>4 yrs. 11 mos. 4 ds.</u> to the State <u>4 yrs. 11 mos. 4 ds.</u>

Where was disease contracted, if not at place of death? <u></u>
Former or usual residence <u></u>

26 19 PLACE OF BURIAL OR REMOVAL <u>Moreland Cemetery</u>	27 DATE OF BURIAL <u>Jan. 6, 1915</u>
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28 20 UNDERTAKER <u>E. B. Crim</u>	29 ADDRESS <u>Gormania W Va</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salsman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

## Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrotis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County..... Gairatt.....

Village or City..... Cullin..... (No. ....)

2 FULL NAME..... Mary Parker.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX..... 4 COLOR OR RACE..... 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word).....  
Female White Single

6 DATE OF BIRTH.....  
August 14, 1913  
(Month) (Day) (Year)

7 AGE.....  
1 yrs. 4 mos. 19 ds. If LESS than  
1 day, .... hrs.  
OR min. ?

8 OCCUPATION.....  
(a) Trade, profession, or  
particular kind of work..... Infant.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

9 BIRTHPLACE  
(State or country)..... Maryland

10 NAME OF  
FATHER..... E. R. Parker.

11 BIRTHPLACE  
OF FATHER  
(State or country)..... Md.

12 MAIDEN NAME  
OF MOTHER..... Rosa Shaffer

13 BIRTHPLACE  
OF MOTHER  
(State or country)..... Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.....  
(Informant)..... E. R. Parker.

(Address)..... Cullin, Md.

15 Filed..... Jan. 4, 1915  
M. S. White  
S. C. B. REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

697  
119  
166  
Registered No. ....

St. .... Ward) ....

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH..... Jan. 3, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 12, 1914, to Jan. 3, 1915

that I last saw her alive on Jan. 3, 1915

and that death occurred on the date stated above, at 4.45 P. M.

The CAUSE OF DEATH\* was as follows:

Anemic poisoning

(Duration)..... yrs. 2 mos. 2 ds.

Contributory  
(Secondary)..... Acute nephritis

(Duration)..... yrs. 2 mos. 2 ds.

(Signed)..... J. R. Parker, M. D.

Jan. 3, 1915 (Address)..... Cleveland, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place.....  
of death..... yrs. .... mos. .... ds. In the  
State..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL..... Cullin, Md.

DATE OF BURIAL..... Jan. 4th, 1915

20 UNDERTAKER..... D. C. Baldwin

ADDRESS..... Cleveland, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tricuspid heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 20 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tricuspid heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 20 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 5 1915

BUREAU. V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLATE OF DEATH

County *Garnett*Village or City *Baltimore, Md.* (No. *S*)

698

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *153*2 FULL NAME *W. W. W. Puckett*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> (Write the word)
6 DATE OF BIRTH <i>January 31st</i>		(Month) (Day) (Year)
7 AGE <i>1</i>		if LESS than 1 day, .... hrs. OR .... min. ?
8 OCCUPATION	yrs. .... mos. .... ds.	

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9 BIRTHPLACE  
(State or country) *Maryland*

## PARENTS

10 NAME OF FATHER *Frank Puckett*11 BIRTHPLACE OF FATHER  
(State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Maggie Allen*13 BIRTHPLACE OF MOTHER  
(State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

15

Filed *1915*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *January 31st*

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*Franklin Hero*, 1915, to 1915,

that I last saw him alive on 1915,

and that death occurred on the date stated above, at \_\_\_\_\_ a.m.

The CAUSE OF DEATH\* was as follows:

*Dead at back of Stillson  
Cause unknown.*

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. W. Puckett, M. D.*Feb 1st, 1915 (Address) *Baltimore, Md.*

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

, 1915

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the **disease causing death** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is *Epidemic cerebrospinal meningitis*); *Diphtheria* (avoid use of *"Group"*); *Typhoid fever* (never report *"Typhoid pneumonia"*); *Lobar pneumonia*; *Bronchopneumonia* (*"Pneumonia,"* unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.* *Carcin-*

*oma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as *"Anæmia,"* *"Anaæmia"* (merely symptomatic), *"Atrophy,"* *"Collapse,"* *"Coma,"* *"Convulsions,"* *"Debility"* (*"Congenital,"* *"Senile,"* etc.), *"Dropsy,"* *"Exhaustion,"* *"Heart failure,"* *"Haemorrhage,"* *"Inanition,"* *"Malaria,"* *"Old Age,"* *"Shock,"* *"Tænia,"* *"Weakness,"* etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as *"Puerperal septicæmia,"* *"Puerperal peritonitis,"* etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*. *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of *"Contributory."* (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 5 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County *Garrett*

Village or City *Oakland* (No. *137*)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *166*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Anna May Tanner*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH *March 29* (Month) *1882* (Year)  
7 AGE *33 yrs. 9 mos. 19 ds.* If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *House Wife*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) *Lang Run*

10 NAME OF FATHER *Richard T. Browning*

11 BIRTHPLACE OF FATHER  
(State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Henrik Twigg*

13 BIRTHPLACE OF MOTHER  
(State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Norman P. Tanner*

(Address) *Oakland Md.*

15 Filed *Jan. 20, 1915* Mark S. White  
Supt. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan. 18* (Month) *1915* (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan. 15, 1915* to *Jan. 18, 1915*,  
that I last saw her alive on *Jan. 18, 1915*,

and that death occurred on the date stated above, at *1445* m.

The CAUSE OF DEATH\* was as follows:

*Miscarriage Septicemia  
from infection Bacillus viridans  
capsules*

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

18 (Duration) yrs. mos. ds.  
(Signed) *W. W. Morris*, M. D.  
*Jan. 20, 1915* (Address) *Oakland Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

20 PLACE OF BURIAL OR REMOVAL *Oakland* DATE OF BURIAL *Jan. 21, 1915*

20 UNDERTAKER *D. E. Balden* ADDRESS *Oakland, Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrotitis*, *ictanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1<sup>st</sup> PLACE OF DEATH  
County *Montgomery*

700

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *166*St; *Ward*)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City *Deer Park* (No. *179*)2<sup>nd</sup> FULL NAME *James R. Specht*

## PERSONAL AND STATISTICAL PARTICULARS

3<sup>rd</sup> SEX *Male* 4<sup>th</sup> COLOR OR RACE *White* 5<sup>th</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED *Momed*  
(Write the word)

6<sup>th</sup> DATE OF BIRTH *Dec 19, 1853*  
(Month) (Day) (Year)

7<sup>th</sup> AGE *59 yrs. 11 mos. 11 ds.* If LESS than  
1 day, .... hrs.  
OR .... min. ?

8<sup>th</sup> OCCUPATION *Merchant*  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9<sup>th</sup> BIRTHPLACE  
(State or country) *Pa*

10<sup>th</sup> NAME OF FATHER *James Specht*

11<sup>th</sup> BIRTHPLACE OF FATHER  
(State or country) *Pa*

12<sup>th</sup> MAIDEN NAME OF MOTHER *Anna Klemm*

13<sup>th</sup> BIRTHPLACE OF MOTHER  
(State or country) *Pa*

14<sup>th</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Mrs Emma Specht*  
(Address) *Deer Park Ward*

15<sup>th</sup> Filed *Jan. 12th, 1915* by *Mark S. White*  
Supt. of Reg. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16<sup>th</sup> DATE OF DEATH *Dec 10, 1915*  
(Month) (Day) (Year)

17<sup>th</sup> I HEREBY CERTIFY, That I attended deceased from *for three weeks*, 1915, that I last saw him alive on *Dec 7, 1915*, and that death occurred on the date stated above, at *8A* m. The CAUSE OF DEATH\* was as follows:

*Sudden fainting & heart*  
(Duration) yrs. mos. ds.  
Contributory (Secondary) *Pleurisy*

(Signed) *M. C. Shumway*, M. D.  
(Address) *Deer Park*  
(Duration) yrs. mos. ds.  
Jan. 12, 1915

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18<sup>th</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19<sup>th</sup> PLACE OF BURIAL OR REMOVAL *Flatwood, Md* DATE OF BURIAL *Jan. 13th, 1915*

20<sup>th</sup> UNDERTAKER *L. E. Bolden* ADDRESS *Deer Park, Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *metastases*, *peritonacum*, etc. *Carcinoma*, *Sarcoma*, etc., of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetanias," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *synsis*, *ictamus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Garrett

701

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 164Village or City Addison, Pa.County St.; Ward 1

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Conrad M. Speicher

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	---

## 6 DATE OF BIRTH

January 31, 1867  
(Month) (Day) (Year)

## 7 AGE

47 yrs. 11 mos. 1 ds. If LESS than  
1 day. hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of Industry business, or establishment in which employed (or employer)

Farmer9 BIRTHPLACE  
(State or country)Maryland

## PARENTS

## 10 NAME OF FATHER

Isaac Speicher11 BIRTHPLACE OF FATHER  
(State or country)Maryland

## 12 MAIDEN NAME OF MOTHER

Elizabeth Speicher13 BIRTHPLACE OF MOTHER  
(State or country)Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Speicher

(Address)

Accident, Md.

## 15

Filed Jan. 2, 1915J. L. Richter

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan'y 2, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY That I attended deceased from

Dec. 22, 1914, to Dec. 29, 1914,  
that I last saw him alive on Dec. 29, 1914,

and that death occurred on the date stated above, at 40. m.

The CAUSE OF DEATH was as follows:

Heart failure

(Duration) 1 yrs. mos. ds.

## Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed) D. Jacobs, M.D.  
Jan'y 2, 1915 (Address) Somerset, Pa.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) Whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. mos. ds. In the State, \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Lohr Cem. Md.

## DATE OF BURIAL

1-4-1915

## 20 UNDERTAKER

C. Rishelbarger ADDRESS Addison, Pa.

# REVISED UNITED STATES STANDARD

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, menin-*

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Sent out to be signed on

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FEB 2 1913

form.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

702

County *Garrett*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *160*

91

Village or City *Swanton* (No.)

## 2 FULL NAME

*Mrs Hannah Spikes*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*  
(Write the word)

## 6 DATE OF BIRTH

*December 2*, 1831  
(Month) (Day) (Year)

## 7 AGE

*83* yrs. *1* mos. *29* ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) *at home* *Housekeeping*

9 BIRTHPLACE  
(State or country)*Hardy Co Virginia*PARENTS  
10 NAME OF FATHER*Enos B. Cooper*11 BIRTHPLACE OF FATHER  
(State or country)*Virginia*

## 12 MAIDEN NAME OF MOTHER

*Haney Murphy*13 BIRTHPLACE OF MOTHER  
(State or country)*Pa. Ia.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William Bremenan*(Address) *Swanton*

## 15

Filed *1-28-1915* *Albert Baker*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*January 27*, 1915  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *On Jan 27*, 1915, to *Jan 27*, 1915.that I last saw him alive on *Jan 27*, 1915.and that death occurred on the date stated above, at *6 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*  
*Feaver* (Duration) mos. ds.  
*to* (Duration) yrs. mos. ds.  
Contributory (Secondary) *to* (Duration) yrs. mos. ds.  
*M. C. Murphy* (Address) *Died and* (Duration) yrs. mos. ds.  
(Signed) *1915* (Address) *Died and* (Duration) yrs. mos. ds.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Edgewood farm* 1-29, 1915

## 20 UNDERTAKER

*F. P. Bernard & Son* ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningiæ, peritonacum, etc.*; *Carcinoma*. *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scars*, *ictemus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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• FEB 5 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Garrett

703

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 172Village or City Kitzmillar (No.)St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Mildred M. Spiker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)
6 DATE OF BIRTH <u>April 7</u>		if LESS than 1 day, ____ hrs. OR ____ min.?
7 AGE <u>12 yrs. 9 mos. 3 ds.</u>		

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Scholar  
 (b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF FATHER Theodore Spiker

11 BIRTHPLACE OF FATHER  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Buckworth

13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Judson Miller

(Address) Kitzmillar, Md.

15 Filed Jan 10, 1915 A. G. B.  
N. S. 19

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 10, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT I attended deceased from Jan 28, 1915, to Jan 9, 1915,  
that I last saw her alive on Jan 9, 1915,  
and that death occurred on the date stated above, at 8 a.m.  
The CAUSE OF DEATH\* was as follows:

Diphtheria

Contributory  
(Secondary) Chronic Valvular  
Heart Disease (Duration) 2 yrs. 4 mos. 4 ds.

(Signed) E. Judson Miller, M. D.  
Day 10, 1915 (Address) Kitzmillar, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mns. ds. In the State yrs. mns. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Harmont DATE OF BURIAL Jan 11, 1915

20 UNDERTAKER Barrett & Co. ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid) *Housekeepers* who receive a definite salary, may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc. *Carcin-*

**oma, Sarcoma, etc., of** (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chro-  
matic heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.** *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "A-  
thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-  
nus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicac-  
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-  
dental*; *Revolver wound of head—homicide*; *Poisoned  
by carbolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *spasms, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**

FFF 3 1915

BU

. . . . .

S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Garrett704  
S  
Village or City Maysville (No.)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 172St.  Ward 

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Stewart

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single6 DATE OF BIRTH Jan 12, 1915(Month) Jan (Day) 12 (Year) 19157 AGE 100 If LESS than 1 day, hrs. OR min. ?  
yrs. 1 mos. 0 ds. 08 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry business, or establishment in which employed (or employer) 9 BIRTHPLACE  
(State or country) Maysville, Md.10 NAME OF FATHER Harry Stewart11 BIRTHPLACE OF FATHER  
(State or country) W. Va.12 MAIDEN NAME OF MOTHER Sylvia Shirley13 BIRTHPLACE OF MOTHER  
(State or country) W. Va.14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(informant) Mrs. Harry Stewart(Address) Maysville, Md.15 Filed Apr 23, 1915 L. C. Bray

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 12, 1915(Month) Jan (Day) 12 (Year) 191517 I HEREBY CERTIFY, That I attended deceased from 191 to 191,that I last saw him alive on 191, and that death occurred on the date stated above, at 191 m.

The CAUSE OF DEATH \* was as follows:

Still - Born(Duration) 0 yrs. 0 mos. 0 ds.Contributory  
Secondary(Signed) H. P. C. L. B. (Address) Blaine, W. Va. (Duration) 0 yrs. 0 mos. 0 ds. M. O. 0

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 191 yrs. 0 mos. 0 ds. In the State, 191 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 19 PLACE OF BURIAL OR REMOVAL Elk Garden, W. Va. DATE OF BURIAL Jan 12, 191520 UNDERTAKER Funerals Shaples ADDRESS Blaine, W. Va.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaoder*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Crocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* (*lungs*, *menin*); *MAY 3 1915* *RECEIVED* *BUREAU, V. S.* *unqualified*, is indefinite); *Tuberculosis* of lungs, menin

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Premenstrual septicemia," "Premenstrual peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

*RECEIVED*  
APR 15 1916  
BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Garnett

705

175

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 166Village or City Oakland (No. )St.  Ward 

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Unknown Slave

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Unknown</u> (Write the word)
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6 DATE OF BIRTH <u>Unknown</u>	(Month)	(Day)	(Year) <u>1</u>
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7 AGE <u>Unknown</u>	YRS.	MOS.	ds.	If LESS than 1 day, .... hrs. OR min. ?
----------------------	------	------	-----	---

8 OCCUPATION (a) Trade, profession, or particular kind of work	<u>Labover</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)			

9 BIRTHPLACE (State or country)	<u>Unknown</u>		
------------------------------------	----------------	--	--

10 NAME OF FATHER	<u>Unknown</u>		
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11 BIRTHPLACE OF FATHER (State or country)	<u>Unknown</u>		
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12 MAIDEN NAME OF MOTHER	<u>Unknown</u>		
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13 BIRTHPLACE OF MOTHER (State or country)	<u>Unknown</u>		
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## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. S. White(Address) Oakland, Md.15 Filed Jan. 14, 1915 Mark S. White  
Supt. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 13, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
191, to 191,that I last saw him alive on 191,and that death occurred on the date stated above, at 191 m.

The CAUSE OF DEATH\* was as follows:

Killed by B. & O. Passenger train  
#1 Jan. 13th. 1915.

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry L. Morris, M. D.  
1915 (Address) Oakland, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oakland DATE OF BURIAL Jan. 15, 191520 UNDERTAKER D. C. Bolden ADDRESS Oakland, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Cook*, *mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-* (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremula," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasms, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1915

BUREAU, U. S. A.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1 PLACE OF DEATH  
County of Garrett  
Village or City Elder Hill (No. 79)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 161

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Martha Van Sickle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH

Mar 26, 1845  
(Month) (Day) (Year)

7 AGE

69 yrs. 9 mos. 12 ds. OR min.?

If LESS than  
1 day, .... hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Garrett Co Md.

Christian Stike

## 10 NAME OF FATHER

Garrett Co Md.

Christian Stike

11 BIRTHPLACE OF FATHER  
(State or country)

## 12 MAIDEN NAME OF MOTHER

Garrett Co Md.

Mary A. Strey

13 BIRTHPLACE OF MOTHER  
(State or country)

Garrett Co Md.

Mary A. Strey

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Lawry Burgess  
(Informant)  
(Address) Friendsville, Md.

15

Filed Jan 9th, 1915 — J. H. Friend

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 7, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1914 to Jan 7, 1915.

that I last saw her alive on Jan 2, 1915.

and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH\* was as follows:

Organic heart trouble  
Mitral Regurgitation (Duration) 6 yrs. 6 mos. ds.

Contributory (Secondary) General Debility

3 decites (Duration) 4 yrs. 4 mos. ds.

(Signed) J. T. Myers, M. D.

Jan 11, 1915 (Address) Markleysburg, Pa.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Sand Spring Jan 10, 1915

20 UNDERTAKER S. Savage ADDRESS

Friendsville, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

oma. Sarcoma, etc., of \_\_\_\_\_ (name origin: "Can-

cer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "An-

emia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-

genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-

mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from

childbirth or miscarriage, as "Tuberous scrophula-

mia," "Tuberous peritonitis," etc. State cause for which surgical operation was undertaken. For violent death's state means of injury and quality as

ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples:

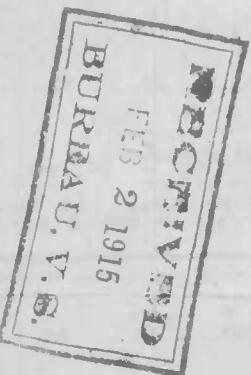
Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the

injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of

cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.* *Carcin-***



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1<sup>st</sup> PLACE OF DEATH  
County Garrett

Village or City New Paris, Md. RD (No.)

707

189

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 166

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

\* FULL NAME Martha A. Wallace

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Sing.  
(Write the word)

6 DATE OF BIRTH

Nov 5, 1863  
(Month) (Day) (Year)

7 AGE

51 yrs. 2 mos. 12 ds. If LESS than  
1 day, hrs. OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work House Work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)MarylandHenry Wallace

10 NAME OF FATHER

Henry Wallace11 BIRTHPLACE OF FATHER  
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Mary A. White13 BIRTHPLACE OF MOTHER  
(State or country)West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James C. Bush(Address) New Paris, Md.

15

Filed Jan. 15th, 1915 Marie S. White

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 15, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw h. — alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Found dead in bed  
forbears combined stomach

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Bradwader, M. D.(Address) Garrett Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

W. B. Hartung, Family Cemetery Date Jan. 17, 1915

20 UNDERTAKER

A. J. Beesley ADDRESS Garrett

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremula," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**  
FEB 5 1915  
BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County, Baltimore

708

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 103St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Bond (No. 20)2 FULL NAME Wright-Will

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb. 16 1897  
(Month) (Day) (Year)

7 AGE 17  
20 yrs. 11 mos. 6 ds. If LESS than  
1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Salmon  
(b) General nature of industry, business, or establishment in which employed (or employer) Salmon

9 BIRTHPLACE  
(State or country) Don't know

10 NAME OF FATHER Don't know John A. Will

11 BIRTHPLACE OF FATHER  
(State or country) Don't know Baltimore

12 MAIDEN NAME OF MOTHER Don't know Mary A. Will

13 BIRTHPLACE OF MOTHER  
(State or country) Don't know Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. P. Jones

(Address) Piedmont 810

15

Filed 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1-16

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1915, to Jan 16 1915,that I last saw him alive on Jan 15 1915, and that death occurred on the date stated above, at 10-6 a.m.

The CAUSE OF DEATH\* was as follows:

Septicemia from infected face

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) D. P. Jones, M. D.(Address) Piedmont 810

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

Big Run near Bond Jan. 18, 1915

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

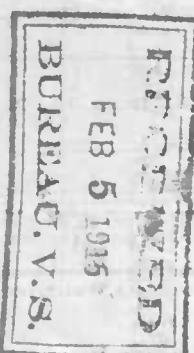
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcin-*

oma, *Sarcoma*, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetany," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County *Granville*

709

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *162*St. *28* Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City *Granville*

(No.)

2 FULL NAME

*Howard Bisserman*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>col. 'n</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>married</i> (Write the word)
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6 DATE OF BIRTH *12-26-1879*  
(Month) (Day) (Year)

7 AGE *87 years*  
If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work *Farmer*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *Unknown*

9 BIRTHPLACE  
(State or country) *Germany*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER  
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER  
(State or country) *Germany*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Unknown*(Address) *Unknown*

15

Filed *1*, 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 6*  
(Month) *6* (Day) *1914* (Year)

17 I HEREBY CERTIFY, That I attended deceased from *12-6-1914* to *12-31-1914*,  
that I last saw him alive on *12-31-1914*,  
and that death occurred on the date stated above, at *8:21 A.M.*,  
The CAUSE OF DEATH\* was as follows:

*Tuberculosis*(Duration) *15* yrs. *mos.* *ds.*Contributory  
(Secondary)(Duration) *15* yrs. *mos.* *ds.*(Signed) *J. H. Jones*, M. D.1-6, 1914 (Address) *Granville*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Crusoe Church* DATE OF BURIAL *Dec 9, 1914*

## 20 UNDERTAKER

*J. M. Winters* ADDRESS *Granville*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Association.]

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FER 3 1915

BUREAU. V.S.